Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

FERNANDO T AVILA MD
PO BOX 120040
SAN ANTONIO TX 78212

Respondent Name:
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number:
M4-12-0980-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the 2011 Professional Encoder, the code 64483 is not included in the list provided to indicate, inclusive or bundled to 77003 or 72100. Also, per Medicare's NCCI edits, the code 77003 and 72100 is reimbursable without a qualifying modifier to unbundled. Therefore, the denial provided by the Carrier is invalid and incorrect. If the carrier can provide information as to where their information is being retrieved can provide me with that information, I will glad [sic] reconsider adjustment of the charges provided in good faith."

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier, or its agent, did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2011	CPT Code 77003	$200.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 11, 2011 and September 12, 2001

- 1 – W1 – Workers Compensation State Fee Schedule adjustment.
- 2 & 3 – 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 1 – No reduction available.
- 2 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Did the requestor bill for the services in dispute in accordance with 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

The insurance carrier denied the disputed service with reason code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." Per the CCI edits, CPT code 77003 is considered a component procedure of CPT code 72275 when performed on the same date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The requestor billed CPT code 77003 with modifier -59 indicating a distinct procedural service performed at a different anatomic site or different patient encounter. Review of the documentation finds that the two procedures were performed at the same anatomical site(s) during the same patient encounter. The documentation does not support that the -59 modifier was used appropriately. The insurance carrier's denial code is therefore supported. Reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 4, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.